

BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation)	
Against:)	
)	No. D-2752
JOHN TAK-TAI CHAN, M.D.)	
License No. A-24557)	N-17076
)	
Respondent.)	
)	

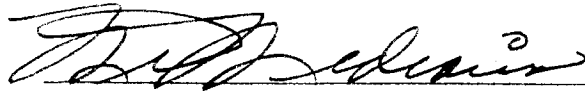
DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Division of Medical Quality of the Board of Medical Quality Assurance as its Decision in the above-entitled matter.

This Decision shall become effective on April 22, 1982.

IT IS SO ORDERED March 23, 1982.

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE



MILLER MEDEARIS
Secretary-Treasurer

BEFORE THE
DIVISION OF MEDICAL QUALITY
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DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation)	
Against:)	
JOHN TAK-TAI CHAN, M.D.)	Case No. D-2752
P O Box 254462)	N-17076
Sacramento, California 95825)	
License No. A-024557)	
Respondent.)	
_____)	

PROPOSED DECISION

This matter came on for hearing before Karl S. Engeman, Administrative Law Judge of the Office of Administrative Hearings at Sacramento, California on January 21, 1982.

Robert C. Cross, Deputy Attorney General, represented the complainant.

Respondent did not appear in person and was not otherwise represented. Proof of attempted service at respondent's current address, reflected in the caption, was established. On or about June 22, 1981, respondent sent to the Executive Director of the Board of Medical Quality Assurance a letter asking that his California medical license be cancelled. To the letter was attached his wall certificate and wallet copy of his certificate. The Division has not consented to the cancellation.

The matter proceeded by default pursuant to Government Code Section 11520. Evidence was received, the hearing was closed and the matter was submitted.

The Administrative Law Judge certifies this decision and recommends its adoption.

FINDINGS OF FACT

I

Complainant, Robert Rowland, is the Executive Director of the Board of Medical Quality Assurance of the State of California and made the accusation solely in such official capacity.

II

At all times mentioned herein, respondent John Tak-Tai Chan, M.D. was a licensed physician in the State of California possessing physician's and surgeon's certificate No. A-024557. Respondent's address of record at the time of the administrative hearing was as reflected in the caption.

III

On complainant's motion, the following allegations were stricken from the accusation: Paragraph IV, subdivision 1, subsections (a), (b), (c) and (e); Paragraph V.

IV

On or about March 26, 1979, respondent administered general anesthesia to Marie F. at Sutter Memorial Hospital for a cesarean section and tubal ligation. The patient was then twenty-eight years old and had an uneventful pregnancy. The anesthesia began at approximately 1:00 p.m. and terminated at approximately 2:00 p.m. During the surgery itself, Dr. Chan reported to the surgeon that he was having trouble with the orotracheal tube and it was eventually replaced by respondent with another tube. At about the same time that respondent reported to the surgeon that he was having problems with the patient's airway, the surgeon noted the patient's blood to be cyanotic (lacking oxygen). This condition improved with the replacement of the orotracheal tube. The baby was born at approximately 1:15 p.m. The baby appeared somewhat cyanotic. Another anesthesiologist was called upon to administer resuscitation to the infant. It took approximately five to six minutes of resuscitative efforts to obtain sustained respiration on the part of the infant. At one minute following birth, the Apgar score for the infant was two, at five minutes the score was six and at ten minutes the score was nine.

V

Respondent failed to note, in his anesthesiology record, the problems with the patient's airway, that the patient became cyanotic and the replacement of the orotracheal tube. Respondent's post-anesthesia note reads as follows, "Tolerated anesthesia well. Awake and responding well." Respondent's failure to mention the significant problems in surgery with the patient and the replacement of the orotracheal tube constitutes gross negligence.

VI

Respondent also failed to note in his anesthesia record the need for five to six minutes of resuscitation to get the infant breathing well on its own. Respondent reported an Apgar score of two at birth and incorrectly reported an Apgar score at five minutes of ten. Respondent's failure to note the correct condition of the baby following birth and the significant resuscitative efforts for five to six minutes on

the baby constitutes gross negligence.

VII

It was not established that respondent improperly placed the first orotracheal tube or that respondent cut the first orotracheal tube in order to make it appear that the tube had been defective and ruptured. It was not established that the patient's problems resulted from improper placement of the first orotracheal tube.

VIII

Respondent failed to accurately monitor and record the patient's vital signs including blood pressure and pulse. The anesthesiology record shows blood pressure and pulse readings which are wholly inconsistent with the patient's obstructed airway and period of cyanosis. The failure to accurately monitor and record such vital signs on the anesthesiology record constitutes gross negligence. Respondent also failed to record the time and dosage of medications administered. Such failure also constitutes gross negligence.

IX

On or about April 4, 1979, respondent administered general anesthesia to patient Jessie O. at Sutter Memorial Hospital for an emergency cesarean section. Respondent failed to perform a procedure known as "rapid sequence induction" which is normally performed on a patient with an emergency cesarean section where the anesthesiologist must presume some stomach contents and danger of aspiration exist. Specifically, respondent did not give pre-oxygenation, did not give the patient Curare or Atropine before induction and did not administer cricoid pressure to prevent regurgitation. This procedure, and the necessity for the performance of this procedure during an emergency cesarean section, are common knowledge among anesthesiologists. The failure of respondent to perform this procedure constitutes gross negligence.

X

Respondent chose for this patient a muscle relaxant known as a "depolarizing" type. Approximately one hour later, respondent "reversed" the effects of the depolarizing agent with the administration of a "non-depolarizing" muscle relaxant. The reversal of the depolarizing agent under these circumstances where respondent would not ordinarily anticipate a lengthy surgical procedure was inappropriate and grossly negligent.

XI

Thereafter, as one would expect, the "dual block" effect of the two types of muscle relaxants caused paralysis in the patient manifested in part by her difficulty in breathing. At this point, respondent did attempt to "reverse" the second,

non-depolarizing muscle relaxant with another drug; but the dosage of this drug administered by respondent was approximately one-tenth the amount required. Respondent repeated the same dosage almost immediately. These facts evidence gross negligence.

XII

Respondent's next step was to administer a narcotic antagonist, presumably to reverse the effects of narcotics previously administered. However, the administration of a narcotic antagonist was inappropriate under these circumstances given the relatively mild, short acting narcotics administered to this patient previously. Further, respondent administered a dose of the narcotic antagonist which was at least four times greater than the normal, incremental dose normally administered to reverse the effects of narcotics. The net effect of respondent's "reversal" of both the original muscle relaxant and the narcotic, analgesic medication was to render the patient virtually paralyzed and in extreme pain. Respondent's conduct in this regard constitutes gross negligence. Respondent's inappropriate use of drugs also demonstrates incompetence.

XIII

This patient was moved to the recovery room and her first recorded recovery room blood pressure was approximately 70/54 with a pulse of 88. At the time respondent first came to the recovery room to check on the patient, her blood pressure was approximately 70 systolic. Respondent ordered two units of packed cells. Respondent then left the hospital to go to another hospital to do an anesthetic procedure. The surgeon noted that the patient had lost approximately 600 ml of blood during the procedure. Respondent did not note the blood loss on his anesthesia record. Thereafter, another anesthesiologist was called to the recovery room by a recovery room nurse. He and another physician began vigorous resuscitation of the patient, including the administration of fluids and whole blood. The patient's blood pressure responded rapidly and rose to respectable levels within a short period. Respondent's decision to leave this patient in a condition of shock, or near shock, without the provision for another physician to take over her care constitutes gross negligence. Respondent's failure to replace the blood loss with fluids and whole blood constitutes gross negligence and incompetence.

XIV

During the administration of anesthesia to this patient, respondent failed to record the dosages of the depolarizing muscle relaxant administered to the patient. Such failure constitutes gross negligence. It was not established that respondent failed to adequately observe and document the patient's vital signs.

XV

While respondent did not testify at the administrative hearing, the anesthesiologist who was called to the recovery room to resuscitate patient Jessie O. did talk to respondent on the morning of the incident about the drugs administered by respondent and his abandonment of the patient. With respect to the drug regimen, respondent remarked that the regimen had been taught to him in school and it was the procedure that he had always followed. With respect to the abandonment of the patient, respondent did not feel that at the time he left the patient that she was "shocky" or in danger in any way.

DETERMINATION OF ISSUES

I

By reason of the findings in Paragraphs IV, V, VI, VIII, IX, X, XI, XII, XIII and XIV of the Findings of Fact, respondent is subject to discipline pursuant to Section 2234(b) of the Business and Professions Code.

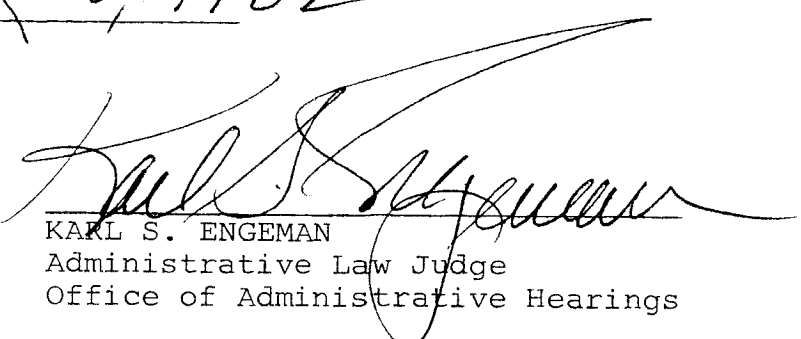
II

By reason of the findings set forth in Paragraphs XII and XIII of the Findings of Fact, respondent is subject to discipline pursuant to Section 2234(d) of the Business and Professions Code.

ORDER

Respondent's physician's and surgeon's certificate is revoked.

Dated: February 10, 1982


KARL S. ENGEMAN

Administrative Law Judge
Office of Administrative Hearings

1 GEORGE DEUKMEJIAN, Attorney General
of the State of California
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4 Telephone: (916) 445-0422

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7

8 BEFORE THE BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
9 STATE OF CALIFORNIA
10

11 In the matter of the Accusation) NO. D-2752
Against:)
12)
JOHN TAK-TAI CHAN, M.D.) ACCUSATION
13 P. O. Box 254462)
Sacramento, CA 95825)
14 License No. A-024557)
15 Respondent.)
16

17 Complainant Robert Rowland alleges:

18 I

19 At all times herein mentioned complainant was and
20 is the Executive Director of the Board of Medical Quality
21 Assurance of the State of California and makes this accusation
22 solely in such official capacity.

23 II

24 At all times herein mentioned respondent John Tak-
25 Tai Chan, M.D. was and is a licensed physician in the State
26 of California possessing physician's and surgeon's certificate
27 no. A-024557 and specializing in the field anesthesiology.

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III

Business and Professions Code section 2234 provides that the Division of Medical Quality shall take action against a licensee who is charged with unprofessional conduct. Unprofessional conduct includes, but is not limited to the following: "(b) Gross negligence, (c) repeated similar negligent acts, (d) incompetence."

IV

Respondent John Tak-Tai Chan, M.D. has committed acts of gross negligence and is therefore subject to disciplinary action pursuant to Business and Professions Code section 2234(b). The circumstances are as follows:

1. Patient: Marie F. - Hospital Chart No. 045959

On or about March 26, 1979 respondent administered general anesthesia to Marie F. at Sutter Memorial Hospital for a cesarean section. Respondent treated and rendered anesthesia services to the patient in a grossly negligent manner and did the following:

a. Respondent improperly inserted the orotracheal tube with the cuff across the true cords, allowing the tube to creep out and allowing secretions to enter the patient's larynx.

b. Respondent failed to recognize the above situation until the surgeons noted the cyanotic appearance of the patient and the ventilator alarm sounded.

c. Respondent failed to utilize proper skill in reestablishing an airway for the patient. The patient

1 went several minutes with a compromised or nonexistent
2 airway.

3 d. Respondent eventually inserted a different
4 orotracheal tube into the patient. Respondent failed
5 to note in his anesthesia record any mention of the
6 entire episode or the changing of tubes or the fact
7 that the baby was born asleep and had to be resuscitated
8 by another anesthesiologist.

9 e. Respondent demonstrated inadequate knowledge
10 and technic in the resuscitation of the baby.

11 f. Respondent failed to adequately monitor and
12 record preanesthetic procedures, vital signs, and the
13 time and dosage of medications administered.

14 g. After surgery respondent cut the original
15 orotracheal tube with an instrument to make it appear
16 as if the original orotracheal tube had been defective
17 and ruptured. In fact the orotracheal tube did not
18 rupture and the extubation was caused by improper place-
19 ment of the orotracheal tube originally.

20 h. Respondent failed to note any of the complications
21 in his post anesthesia note which read, in its entirety:
22 "Tolerated anesthesia well. Awake and responding well."
23 Respondent failed to make any entry into the records
24 anywhere which would alert any other physician treating
25 the patient to the fact that the patient and the baby
26 had experienced a significant hypoxic episode.

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1 2. Patient: Jessie O. - Hospital Chart No. 261993

2 On or about April 4, 1979, respondent administered
3 general anesthesia to patient Jessie O. at Sutter Memorial
4 Hospital for an emergency cesarean section. Respondent
5 treated and rendered anesthesia services to the patient in a
6 grossly negligent manner and did the following:

7 a. The patient had a suspected full stomach.

8 Respondent failed to take adequate intubation precautions.
9 No preoxygenation was given, no pretreatment with curare
10 or atropine was given before induction, and no cricoid
11 pressure was administered.

12 b. Respondent failed to adequately observe and
13 document vital signs and the times and dosages of drug
14 administration.

15 c. The drugs administered by respondent to the
16 patient were inappropriate in type and dosage. One
17 result of this drug mismanagement was that the patient
18 entered recovery room experiencing significant pain due
19 to the lack of anesthesia, but was paralyzed and unable
20 to express her condition.

21 d. Respondent failed to adequately manage the
22 patient's post surgical vascular collapse, and left the
23 hospital for another procedure at a different hospital
24 while this condition continued to exist.

25 Such conduct on the part of respondent is cause
26 for disciplinary action pursuant to section 2234(b).

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V

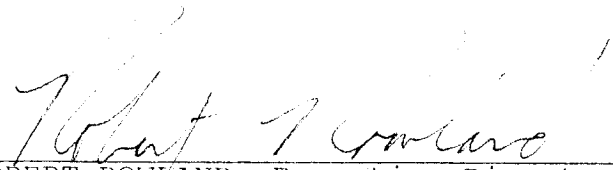
Respondent John Tak-Tai Chan, M.D. is guilty of repeated similar negligent acts and is therefore subject to disciplinary action pursuant to Business and Professions Code section 2234(c). The facts and circumstances are set forth above.

VI

Respondent John Tak-Tai Chan, M.D. is guilty of acts of incompetence and is therefore subject to disciplinary action pursuant to Business and Professions Code section 2234(d). These acts and circumstances are set forth above.

WHEREFORE, complainant prays that hearing be held on the matters alleged herein and that following a hearing license of respondent be revoked or suspended or such other and further action be taken as deemed proper and just.

DATED: May 28, 1981


ROBERT ROWLAND, Executive Director
Board of Medical Quality Assurance
Department of Consumer Affairs
State of California